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Dental DimensionS

Fall 2015

- 4th Annual Afternoon Tea
- Office Redesign
- Documenting Veneer Cases
- Alveolar Ridge Preservation

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Dental DimensionS

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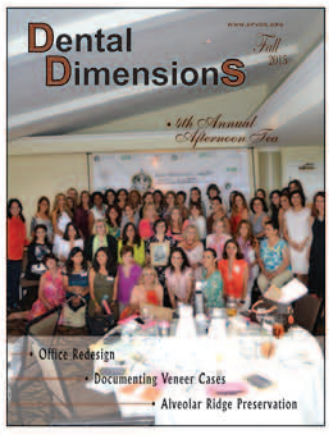
In This Issue

Fall 2015

Volume XLIX Number 4

Call for Submissions

Do you have an unusual case study or an interesting article you would like to have published? Dental Dimensions is looking for articles from our members so we can share our collective knowledge. Articles should be 500-1000 words with references where applicable and photos if possible. Send your submissions to:
shukandds@gmail.com
or contact the dental society office at 818-576-0116



On The Cover.....

Participants at the 4th Annual Tea at the Braemar Country club, gathered for a group photo.

From the Desk of the Editor

Shukan Kanuga DDS, MSD.
Board Certified
Pediatric Dentist

Opportunities of community involvement around us abound and dentists have been known to get involved from time to time. This summer I was introduced to an exemplary act of selfless volunteering, which I would love to share with you.

Parishi, a 10 year old girl in Los Angeles was getting excited about her summer vacation after 5th grade. Like many summers in the past, she would be spending most of it with her grandparents in India. An independent minded, sometimes goofy, very creative and out-of-the box thinker, she is always up to something that surprises her parents! She and her mom were brainstorming about how she could use her time in India in a somewhat meaningful way rather than spending it in front of the screens all day long. She loves playing "school" and can command great attention from her younger brother's friends when she is their teacher! This passion for teaching mixed with empathy for the thousands of underserved children in India that she had witnessed in the past led to her summer project, "Kids teach kids".

In the city of Ahmedabad (birthplace of Mahatma Gandhi), Grandma had a task prepping for Parishi's visit. She visited the neighborhood slums and talked to the parents of the children to see if they would be interested in going to a special class taught by a young girl. Grandma would accompany Parishi to their makeshift houses where the "school" took place for the first few evenings until they won the parents' trust. Starting the second week, a dozen kids ranging in ages from 5 to 13 would show up every evening at Parishi's grandparents' home, very excited and eager to learn. She would teach them the basics of reading, phonics, writing and grandma and great grandma would also help with Math. The class size kept growing as word got around about this fun and high-spirited teacher visiting from the States! Parishi had her moments of frustration when there were more than 20 kids, some of whom were older than her and too hard to control. On days like that, the whole family would be involved in teaching them. She would divide them into groups based on their level and assign work to each group. Her five year old brother would join in a month into this when he arrived, and enjoyed teaching alphabets and spelling to the younger kids. Parishi had to choose between roller-skating lessons versus this project as the times conflicted and she chose to continue the latter.

I happen to be Parishi's mom. I am sure this self-assigned project of hers was a valuable life-experience for her, however it was very impactful for me and I learned a few life lessons myself. When I went to India to pick up the kids, I was able to witness and participate in "Parishi teacher's" school. I was appalled at the level of education and the disparities that exist in the schools amongst the children. I was also deeply saddened to find how a lot of these children came from households, where education was very low on the priority list. Getting two square meals a day, clothes to wear and a shelter to live under took precedence. On the brighter side, I was amazed to see how these kids were very eager to learn. To some of them, the hour spent at Parishi's grandparents' home was the most exciting part of their life! The farewell was special for all of us with the local radio station interviewing Parishi and me and covering the story with a photo shoot.

Parishi had hoped to inspire other fortunate children like her to do their share in spreading the light of education and she was successful in setting a precedent for that. I have had many parents and children ask me about how she managed to pull this through and how they can help. My mom had promised the kids to always be available to tutor whenever they had road-blocks in their school work. Little acts of kindness can go a long way in bringing a positive change in the world around us. And sometimes little people can be bigger heroes than we'd ever have imagined!

Ciao,
Shukan

Letter to the Editor

Hi Shukan,
I want to thank you for a wonderful issue; very impressive publication. I have been in the SFVDS for 44 years and this is the best one ever. And please thank Michael Simmons for his excellent information on corporate dentistry. Keep up the fabulous work.

Frank Niver

Leadership and Governance

From the Desk of the President

Michael S. Simmons, DMD

Acting as a household leader commonly referred to as a "parent", one may exercise a certain amount of control of the house. This control may be perceived as a dictatorship or a democracy depending on the age and maturity of other household members and their input in decision making. A dictatorial order may be essential in promoting survival of the very immature members of the house. However, as the young mature, the control and decision making may evolve into a more democratic process. Of course a family of just one has little issue with internal governance but as the household inhabitant numbers increase and various perspectives increase, the household order becomes more complex.

Looking at world order or limiting the view to the governance of the U.S., one gets a more extreme sense of the complexity of maintaining order. It is the balance between an ability to hear and act upon the voice of one and yet not be governed by a single voice…unless of course a true dictatorship exists. A government accountable to its citizens is one of the cornerstones of an open society which we may aspire to.

The democratic process within a society is just one of the many ordering systems of communities or nations. Democracy may not be the quickest process to decision making but that is the price to pay for allowing the single voice to be heard. Balance of power in such democratic communities may periodically come under scrutiny as those in power may self-protect their power and seek to gain more control thereby upsetting the existing balance. The famous saying goes "power corrupts and absolute power corrupts absolutely" and therefore there is an underlying and ongoing reassessment of power to maintain balance.

Enter your very own CDA and their ongoing balancing of power in leadership. In CDA there are three centers of power that serve to balance the direction and control of CDA's future. First there is the executive branch centered in Sacramento. It is made up primarily of paid employee, non-dentists organized under an executive director and associated with a few volunteer dentists that exist in short term positions as an Executive Committee (Ex-Com). The paid employees manage the day to day business workings of the association and the Ex-Com is voted in as elected officials on a year- to-year basis. This group meets the most frequently of the three CDA centers of power.

The second balancing branch of power is the CDA Board of Trustees, which according to CDA's website is comprised of "52 members, 43 of which are trustees representing the 32 component societies, and nine of which are officers and ex officio members of the Ex-Com." To me this has the feel of a senate. This group meets less frequently with a minimum of four face-to- face meetings per year.

The third balancing branch of power is the House of Delegates which is made up in 2015 of 209 delegate members, including six dental students, and represents each of CDA's 32 component dental societies according to the number of individual CDA members in that component. Components send between two and 19 delegates to the House and our component, the SFVDS which has a little more than 1330 members is apportioned 11 delegates. The

Continued on page 10

Trustee's Report

What Can CDA Do For You?

By: Martin Countney, DDS

More than twenty years ago when I first became part of "Organized Dentistry" my first position was program chair for the San Fernando Valley Dental Society (SFVDS). My goal was to bring speakers to the SFVDS continuing education courses that were relevant and useful to the SFVDS membership. My simple approach was to call dentists and ask, "Who do you want to speak at our meetings next year?" I called specialists as well as general dentists. If I heard the same name more than four times (out of about 20 calls) I added that name to the list of potential speakers. The next step was to make sure the speakers covered as many areas of dentistry as possible and would have appeal to staff as well as the dentist. This give-the-people-what-they-want approach proved to be record setting in number of attendees.

Now, as one of two CDA trustees I am looking for that same input from SFVDS members. What can CDA do for you, its members? What would CDA have to do to make you a raving fan and refer your non-member colleagues to join CDA? My email address is openplzdds09@gmail.com. My cell number is (818)216-4811.

The Board of Trustees continues to take action the Board believes will benefit members. This includes a proposal to offer mediation in addition to Peer Review. Mediation has the benefit of a less formal process (and much less intimidating) where disputes can be resolved quicker. Just as with Peer Review, neither party is charged a fee to use mediation, but since the cost to administer mediation is less for CDA and SFVDS, mediation can help keep your dues down. Several other states that are using mediation report both patients and members like it as another way to avoid expensive civil lawsuits.

CDA continues to move forward with The Dentists Service Company (TDSC) which will be a truly great benefit to you. CDA's Practice Support Center has been moved to TDSC and all the functions that are currently included in your CDA membership will continue to be at no additional cost. Your questions on employment practices, dental benefit plans, regulatory compliance and much more can be found there. Also the Practice Support Center is sponsoring several seminars on buying or starting a practice. TDSC is developing a group purchasing plan that should allow even small practices to get the benefits of large group purchasing prices.

As a member of CDA you have access to TDIC Professional Liability Insurance. Did you know that TDIC rates have not gone up in 20 years? Is there any other insurance that you have that can say that?

My last Trustees' report was concerned with the possible changes in the way CDA is organized. Two weeks from when I write this report, the CDA House of Delegates (HOD) will be considering all the recommended changes. My next report will cover what happened at the HOD and most important, how that may affect you and your practice.

Legislative Committee Report

By: *Jim Mertzel, DDS*

Denti-Cal Reimbursement

A recent report by the Department of Health Care Services found that since 2008 the number of Denti-Cal providers has declined 15% while five million more Californians have enrolled in the program during that time frame. A primary reason for the lack of provider participation is that the California provider reimbursement rates are among the lowest in the nation. Although the Governor and the legislature agreed to eliminate the existing 10% rate cut in fees that had been in effect since 2013, nothing has been done to increase the rates established in 2000. One of the primary issues for which CDA has been advocating is to increase the rate of reimbursement which is now only 35% of the national average.

As a concerned health-care provider and as a private citizen each one of us can effect change on this important budgetary issue. In the months preceding next year's election you will be invited to attend open houses, town hall meetings and fund raisers for our local legislative leaders and candidates. I urge you to become involved, attend these affairs and express your opinion.

Tobacco Tax

CDA is a member of the coalition, "Save Lives California" which is advocating for an initiative to be placed on the ballot to increase the tobacco tax by $2.00 per pack. The current tax is 87 cents per pack, ranking 35th among the states. Raising the cost of tobacco products is a proven way to decrease use and will also help offset the long- term costs of tobacco use to the health care system. When the cost of a pack of cigarettes increases by 10%, youth smoking decreases by 7%. Tobacco related deaths are the single most preventable cause of death in California claiming more than 40,000 lives a year. In addition tobacco related illnesses costs the state more than $13 billion including $3.5 billion in Medi-Cal costs annually.

AB 648 Virtual Dental Home Grant Program

(This is now a 2-year bill)

Using telehealth technology, a program will be established to allow a dentist in a remote location with the use of transmitted photos and x-rays taken at certain community settings, by a specially trained dental assistant and or hygienist, to authorize the trained auxiliary to perform certain procedures (i.e.: Interim Temporary Restorations). AB 1174 (the Virtual Dental Home (VDH) model) was enacted into law last year. Under this grant program, using public and private funds, the state would provide $4 million for startup elements such as training equipment and technical support to help to advance the VDH model in underserved areas.

(Please allow this reporter to inject his personal perspective on this issue. I would favor the bill if I could be assured that this service will be provided in "REMOTE" locations, not necessarily in "UNDERSERVED" locations. For example, there may be what is referred to as "UNDERSERVED" areas in the San Fernando Valley and in parts of Los Angeles. There are dentist in those areas where a large part of their practice is comprised of Denti-Cal patients. Some may classify those locations as "UNDERSERVED". In that situation, in urban areas, it would not be necessary for specially trained auxiliaries to perform a service, when local dentists are available. The procedures performed within locations in urban areas by auxiliaries should only be to take x-rays, provide a visual report and photos to enable the remote dentist to diagnose and refer. In those cases the patient could and should be referred.)

CURES PRESCRIPTION DRUG DATABASE

CDA opposed SB 482 , which required a prescriber to check a patient's prescription history before prescribing a Schedule II or III substance.

Dental Director/State Oral Health Plan

Jayanth Kumar D.D.S. MPH was appointed the State Dental Director effective August 1, 2015. CDA will be working closely with him and other stakeholders to develop a state oral health plan.

Dental Plan Accountability

AB 1982, a bill sponsored by CDA, was passed into law last year. It requires dental insurance plans to be accountable for the amount they allocate for patient services as opposed to the amount allocated for administrative costs. Medical insurance companies are required to have a MLR of 80% (80% to be spent to pay for medical services). At the present time there is no such requirement for dental insurance companies. The bill required that by 2018 the Legislature establish a MLR for dental insurance companies. For the next several years the dental insurance companies are required to submit audited reports (the first report is due September 1) to help determine a reasonable MLR.

AS I HAVE IN THE PAST, I ENCOURAGE EVERYONE TO BECOME INVOLVED IN THE POLITICAL PROCESS. 2016 WILL BE A CRITICAL YEAR FOR OUR STATE AND OUR COUNTRY. MEET THE CANDIDATES . ATTEND THEIR OPEN HOUSES, CONTIRBUTE TO THEIR CAMPAIGNS. NEXT YEAR SOME OF THE MEMBRS OF OUR LEGISLATIVE COMMITTEE WILL MEET IN SACRAMENTO WITH SOME OF OUR LOCAL STATE LEGISLATORS. IF YOU WOULD LIKE TO BE A PART OF THAT COMMITTEE PLEASE CONTACT THE SFVDS OFFICE.

Meet and Greet with Senator Bob Hertzberg

By: Andy Ozols, Executive Director

Senator Hertzberg with the evening's hosts, SFVDS Legislation Chair, Dr. Jim Mertzel and his wife Mary Anne

As Legislative Chairman of the San Fernando Valley Dental Society, Dr. Jim Mertzel invited State Senator Bob Hertzberg to attend a potluck dinner at his home on Sunday, August 9.

Senator Hertzberg previously served as Speaker of the State Assembly and has earned the respect of most legislators on both sides of the aisle.

Those in attendance were given Senator Hertzberg's philosophy on governing and how he sets priorities. In the process, all in attendance were amazed at how well informed and well-spoken he was on a wide variety of issues, including those that affect dentistry.

The pictures on this page show you what a great time everyone had, how relaxed the atmosphere was and what a terrific host the Mertzels were.

Those in attendance included Drs. Snow (SFVDS Secretary), Gereis (Ethics Chair), Simmons (SFVDS President), Rathee (SFVDS President-elect), Cohen (SFVDS Immediate past-president, Leung (Glendale/Foothills Liaison, Irani (SFVDS Treasurer), Dixit (Leadership Development Chair), Metrzel (legislation chair), Courtney (CDA Trustee), Alvarez (Media Relations Chair) and Andy Ozols, Executive Director.

New changes to sick leave law approved

By: CDA staff

A new bill has been signed by Gov. Jerry Brown to clarify and simplify requirements under the new sick leave law in California, which went into effect July 1 and requires employers to provide three paid sick days each year to their employees.

AB 304, which became effective July 13, does not change the three-day sick leave law, but is intended to alleviate some of the difficulties in implementing its requirements. Most importantly for dentists, the bill provides flexibility for existing paid sick leave plans, allows for alternative accrual for non-hourly payroll, and creates more flexibility in calculating sick pay for non-exempt employees. The bill makes other minor and technical changes.

Below are the bill's main goals.

Clarification About Who is Covered

The passage of this amendment clarifies that employees who work in California for the same employer for 30 or more days within a year are entitled to receive the benefit.

Flexibility for Existing Paid Sick Leave Plans

Clarifies that employers are not required to provide additional paid sick days if they already had a policy prior to Jan. 1, 2015, that provided employees at least three sick days a year and met the specific requirements outlined in the law.

Alternative Accrual for Non-Hourly Payroll

The payroll systems for many employers do not track their employees on an hourly basis. Rather, employees typically accrue such benefits on a per day, pay month or other similar basis. AB 304 allows employers to comply with state law if they accrue, provided accrual is on a regular basis, or front-load their sick leave policies so employees receive no less than three paid sick days by the 120th calendar day of the year or 12-month period. This significantly changes the employer's obligation to track an employee's actual hours worked.

Flexibility for Calculating Sick Pay

Nonexempt employees often perform work at varying rates of pay, which can make it difficult to calculate the rates at which sick leave is paid to employees. Employers can now choose between the methodology required under AB 1522 as well as the more familiar "regular rate of pay," which in essence divides an employee's total pay (hourly pay plus bonuses and/or commissions) in any workweek by the total number of hours worked in that workweek. In California, total pay is divided by no more than 40.

For more information about the new sick leave law, click here (http://www.cda.org/member-resources/practice-support/employment-practices/sick-leave-law)

When is Too Much Really Too Much?

By: Robert D. Stevenson, DDS
Member, CDA Judicial Council

The practicing dentist is under pressure from a variety of sources. Among these, financial pressures can be unrelenting, compelling a dentist to look for ways to increase revenue. Despite these pressures however, it is critical that treatment planning always be in the best interest of the patient.

In these situations, it is helpful to look at our codes of ethics for guidance. Section 1 of the CDA Code of Ethics states "Service to the public is the primary obligation of the dentist as a professional person. Service to the public includes the delivery of quality, competent, and timely care within the bounds of the clinical circumstances presented by the patient." The ADA Principles of Ethics and Code of Professional Conduct (ADA Code) also offers assistance in resolving this dilemma. The Preamble to the ADA Code states that the ADA "calls upon dentists to follow high ethical standards which have the benefit of the patient as their primary goal."

We see in addition, in Section 5.B.6 of the ADA Code, that "A dentist who performs unnecessary dental services or procedures is engaged in unethical conduct." Of course, one of the challenges lies in how we define unnecessary or excessive treatment. An effective litmus test may be to ask "Who will benefit more from the proposed treatment: the patient or me?"

It is also important to consider the ethical principles involved. Autonomy is paramount in our dealings with patients. Obtaining informed consent from your patient shows respect for their autonomy. This must be balanced with our paternalistic tendencies (trust me, I'm the doctor). Ethically, our authority as the doctor should not be used to achieve selfish ends.

Beneficence and its corollary principle non-maleficence are also important principles to consider. "Will the proposed treatment irreparably damage healthy tooth structure?" is a question that could be asked. Justice and integrity also come into play. We should affirm doing the right thing even when outside interests are in conflict with our values and conscience.

Dentists should avoid recommending treatment "upgrades" in order to maximize profits that may be limited because of third party restrictions. Employee dentists should be wary of compulsion to meet high production quotas by performing treatment that may not be in the patient's best interest. Ultimately, it is your license on the line. You must determine what is right. Additional resources about overtreatment are available at cda.org by clicking on the Practice Support tab. For further guidance, consult with a member of your component ethics committee.

From the Desk of the President

Continued from page 5

delegates appear to me to be functioning in some ways as the congress and as such act more as the voice of the "people". The CDA House of Delegates meet minimally once yearly and are scheduled in 2015 to meets October 16-18 in Sacramento. While they meet less frequently, the House of Delegates, according to CDA's by-laws, is the ultimate decision making body of CDA up until now controlling the funding aspects or purse strings of CDA.

For many years CDA governance has functioned well under the balancing act of the three powers but California codes and regulations could conceivably challenge CDA's governance structure. For this reason there are many resolutions at the 2015 CDA House of Delegates addressing the future governance of the CDA. Some issues arise from viewpoints that smaller groups such as the Ex-Com and trustees may be unduly influenced by others in the executive branch and therefore the House of Delegates can serve as oversight. Other viewpoints are that delegates are not all sufficiently informed to make good decisions. Of course there are many viewpoints and other ongoing issues such as saving the cost of certain committees, scope of practice, being responsive to members and staying relevant for the younger members. The outcomes of the house will be very exciting and by the time you read this column the 40 resolutions now being considered will have been voted on.

This is my last column as the SFVDS President and it has been my honor to serve you and lead our component's perspective at CDA. We are one of the most vocal and active of the CDA components and were one of the major voices fighting mid-level providers coming to California. We will continue to voice our opinions and help maintain the great leadership at CDA. Stay tuned for the outcome of our efforts on your behalf and I encourage each one of you to become more involved in leadership at CDA so your voice may continue to be represented and to be heard. Regardless of any outcome I believe we have been able to help dentistry as a profession and protect the well-being of our patients through our strong commitment to organized dentistry.

General Meeting Review

Sept 16
Reconstructive Surgery

Bob Hale, DDS

SFVDS' own past-president, Bob Hale, DDS reviewed the latest advances in reconstructive surgery based on his experiences as an oral surgeon in the U.S. Army during the Iraq and Afghanistan wars. This captivating lecture gave the attendees a greater understanding of what is possible and the successes that are now achievable, all courtesy of extensive research and methodology developed in the Army.

Oct 14
Technology and a Paperless Office

BJ Moorhead, DDS

Attendees learned how to completely make the transition from years of doing it the old way with paper records, charts and files to paperless-without the normally expected frustrations. He spoke about using digital tools to run a practice more efficiently. Dr. Moorhead, a past-president of the Kentucky Dental Association, showed everyone how he did it and he taught the attendees how they too could do it, easily and in a step-by-step manner.

General Meetings -Preview

November 18, 2015

Dental Materials & Bonding
Raymond Bertolloti, DDS

2PM – 9PM Airtel Plaza Hotel, 7277 Valjean Ave., Van Nuys, CA 91406 818.997.7676

Adhesive dentistry has not fully replaced traditional mechanically retained dentistry for many reasons. Lack of trust in adhesives, perceived difficulty, and "It wasn't what we were taught in dental school" are commonly heard. Now that we have proven methods to strongly adhere not only to enamel, but in fact to dentin and all restorative dental materials, there are many compelling reasons to stop doing "hack and pack" tooth destructive dentistry. Learn about the latest advances and methods at this lecture.

2016 General Meeting Lineup

(Watch your emails for our annual 'Season's Pass' discounts)

January 27	Gordon Christiansen, DDS	The Christiansen Bottom Line.
February 24	James Grisdale, DDS	Emerging Trends in Periodontics and Keys to Successful Bone Grafting.
March 30	Carla Cohn, DDS	Practical Pediatric Dentistry for the General Practitioner.
April 20	Ms Diane Morgan Arnes, RDH	CA Dental Practice Act and Infection Control.
June 22	Douglas Young, DDS	Dental Materials, With an emphasis on Caries Management.
September 21	Kyle Stanley, DDS	The Biggest Problems in Implant Dentistry.
October 19	Bob Lowe, DDS	Esthetic Dentistry for the General Practitioner.
November 16	Ms Olga Ibsen, RDH, MS	Oral Pathology for the Dental Professional and Differential Diagnosis of Oral Lesions.

Alveolar Ridge Preservation Combined with Collagen Plug, Soft Relining Flipper and Early Implant Placement in the Esthetic Zone:

A Case Report.

Early implant placement in the esthetic zone for restoring anterior teeth is considered a complex treatment and one of the treatment options. The surgical and prosthetic techniques described in this article are characterized by extraction of non-restorable teeth with flapless procedure, and simultaneous placement and stabilization of a collagen plug, a two month soft tissue healing, and correcting gingival contours with a soft relined flipper, implant placement and finally a restoration with two crowns. A case report is presented that illustrates the step-by-step procedures.

Key Words: tooth extraction, ridge preservation, early implant placement, collagen plug.

Introduction

The alveolar ridge deformations occurring in the esthetic zone in the anterior region of the maxilla followed by tooth extraction may cause serious esthetic and functional problems. The remodeling process related to horizontal and vertical dimensional changes leads to formation of soft tissue defects. Implant therapy is often considered one of the best treatment options.

Van der Weijden et al.[1] reported that the clinical loss in horizontal direction is greater than the loss in vertical direction assessed both clinically and radiographically in their systematic review. The study by Zuhr O. et al.[2] concluded that the maintenance of the ridge contour will often help all further therapeutic steps. Socket preservation in combination with different techniques of implant placement can be a valuable procedure for single tooth replacement.

Various methods and different types of bone substitutes used to minimize alveolar bone resorption are well documented in the literature as showed by E. M. Tomlin et al.[3] in their review. In other words, contemporary implant therapy's main goal is to reach the harmonization of gingival margin without quick changes in tissue architecture including preserving intact papillae and maintaining convex contour of alveolar crest as recommended by Buser D. et al [4].

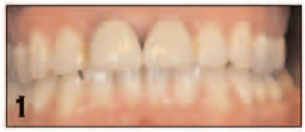
The study by Fickl S.et al.[5] concluded that the socket preservation procedures are able to limit but not avoid the contour alterations after tooth removal. Moreover, use of a free soft tissue graft to seal the socket after extraction might be questioned. The study by *Kotsakis G. et al.*[6] introduces the "socket-plug" technique. The basic steps of this technique contain: tooth extraction, insertion of biomaterial graft in the extraction site and placement of a collagen plug for stabilization. The "socket-plug" technique can help dentists offer the best possible result with the least patient discomfort.

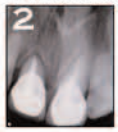
The authors *Hammerle CHF et al.*[7] also found that the techniques designed for ridge preservation included two different methods: i) maintaining the ridge profile, ii) enlarging the ridge profile. In the esthetic zone a high risk for mucosal recession is occurring. "Hence, it should only be used in stringently selected situations with lower risks and only by experienced clinicians."

In this case, I used a modified "socket-plug" technique at the time of tooth extraction, providing a scenario where the fresh socket will be covered with collagen plug by preventing collapse of bone and blood clot formation without using biomaterials.

A Case Report

A 25-year-old, non-smoking female came to the dental office complaining of severe mobility with pain of the maxillary central incisors. Her medical history was noncontributory and the patient was in good general health. Extraoral examination was non-significant. These incisors were previously restored with PFM (Porcelain Fused to Metal) crowns. During my clinical intraoral examination, I found class III mobility on teeth # 8 and # 9 and revealed a probing depth of 5 mm. The mobility of the teeth was apparent at clinical assessment with pain and slight inflammation of marginal tissues (Figure 1). The periapical radiograph showed resorption of roots with teeth #s 8 and 9. The crown-root ratio was 2:1(Figure 2).

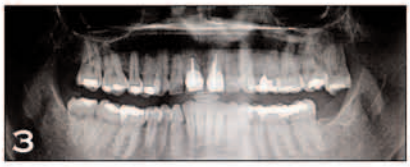


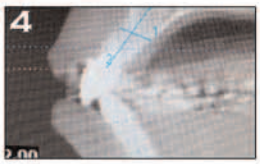


Central incisors were considered hopeless and a decision was made to perform early implant placement. Due to a favorable prosthetic field in the upper anterior area, I chose to insert two dental implants in the region of # 8 and # 9. The treatment plan was discussed with the patient and

Continued on page 13

informed consent was obtained. Following clinical-surgical measurements, radiographic exam (Panoramic Rx) (Figure 3), a study model and CT (Figure 4) were performed.

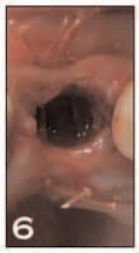




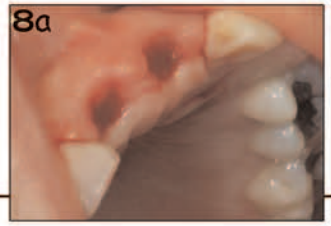
An AB implants system was selected for rehabilitation of the site.

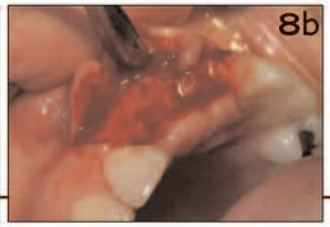
Four tablets of Amoxicillin 500 mg were taken by the patient one hour before surgery. Patient was instructed to rinse with Chlorhexidine 0.12% (Peridex) at the beginning of surgery intervention for one minute.
After local anesthesia (Lidocaine HCl 2% Epinephrine, Lignospan, Septodent) was injected, surgical extraction of the maxillary central incisors was performed (Figure 5a).

The sockets were evaluated (Figure 5b). Collagen plugs (HeliPlug, Miltex-Integra) were introduced and packed into the sockets in order to help form the blood clot and stabilized with transversal single sutures (Figure 6).

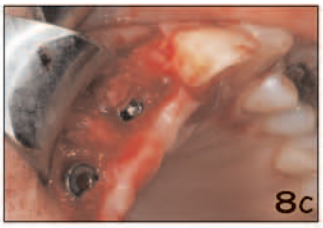


A temporary, removable partial denture (Flipper) was adjusted and fitted (Figure 7a). Soft Reline (Coe-Soft, GC America) was applied on top of the flipper in a way that a portion of the soft reline material went deep into the socket for stability in order to preserve the marginal convex counter (Figure 7b). Healing of the sockets was observed every week over the next two months and modifications of soft reline were performed for creation of alveolar socket architecture. After eight weeks, the first stage surgery was performed. A mid-crestal incision was made and full thickness flap was elevated (Figure 8a & 8b).



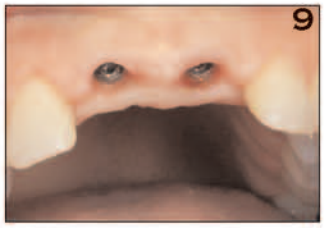


By: Igor Roshkovan DDS
-Private Practice, Los Angeles, CA, USA
-Current student in Master of Science (MSc) in Oral Implantology Program, Gothe University, Frankfurt, Germany.

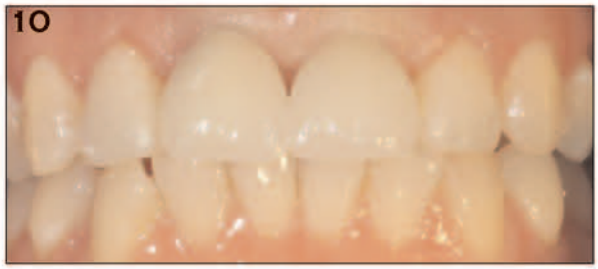


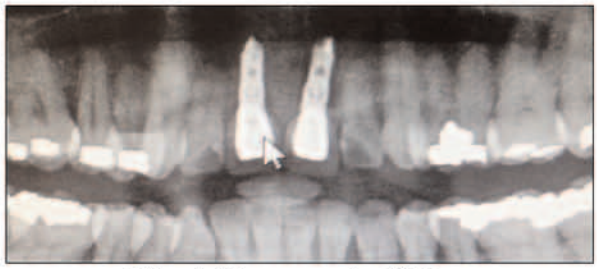
Two implants (Figure 8c) 3.5 _ 11.5 mm were inserted (AB implant, AB Dental Devices Ltd. Ashdod, Israel).

Two months after implantation, the stage-two surgery was performed and implants were uncovered (Figure 9).
The gingival margin profile was optimal for crown placement.



Zirconia ceramic crowns were cemented 2 months after implant placement (Figure 10).





Final Panoramic XRay

Discussion

As recommended by Negri,B.,et al[8] predictable results with superior esthetics can be accomplished if alveolar ridge collapse can be prevented and minimized. It has been reported by Landsberg[9] that the socket seal surgery technique is a successful procedure for ridge preservation and is effective in providing the essential conditions for the positive regeneration of the ridge's hard and soft tissues, including the capability to improve functional and esthetically acceptable sites.

Continued on page 14

Alveolar Ridge Preservation Combined with Collagen Plug, Soft Relining Flipper and Early Implant Placement in the Esthetic Zone: Continued from page 13

A Case Report.

When the practitioner is performing extractions, horizontal and vertical bone resorption is an essential process in natural development.

Results of this case study demonstrate a well maintained alveolar ridge volume using the modified "socket-plug" technique, which did not require any additional alveolar ridge augmentation procedures.

Conclusion

Different options are available for dentists to preserve the ridge after extraction. Based on this case report, modified "socket-plug" technique surgery seems to be an effective procedure to optimize hard and soft tissue environments. The most important benefit of this approach includes protection of the soft tissues using soft reline.

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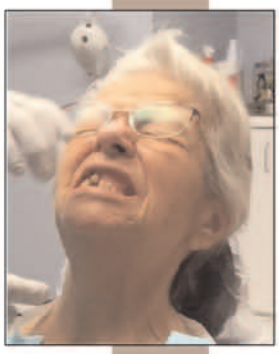
Smiles From the Heart



THANK YOU!

The San Fernando Valley Dental Society Foundation and the patients that have been served by its Smiles From the Heart program, wish to express their warm and heartfelt thanks to those members who have voluntarily worked to alleviate their pain and restore their dental functionality and smiles.

Nooshi Akavian, DDS - Tarzana
Jorge Alvarez, DDS - Tarzana
Henide Arias, DDS - Reseda
Rex Baumgartner, DDS - Newhall
Martin Courtney, DDS - Northridge
Nita Dixit, DDS - Studio City
Mahfouz Gereis, DDS - Panorama City
Gary Herman, DDS - Valley Village
Birva Joshi Jones, DDS - West Hills
Andre Kanarki, DDS - Palmdale
Shukan Kanuga, DDS - West Hills
Kavian Kia, DDS - Encino
Bob Kogen, DDS - Newhall
Chi Leung, DDS - Glendale
Randy Lozada, DDS - Palmdale
George Maranon, DDS - Encino
Afshin Mazdey, DDS - Northridge
Jim Mertzel, DDS - Sunland
Jorge Montes, DDS - N. Hollywood
Sarah Phillips, DDS - Santa Clarita
Anita Rathee, DDS - West Hills
Teresa Romero, DDS - N. Hollywood
Phillip Sacks, DDS - Woodland Hills
Michael Seastrom, DDS - Tarzana
Michael Simmons, DMD - Tarzana
Gib Snow, DDS - Palmdale
Mark Stein, DDS - Encino
Val Shabani, DNT Dental Labs - Tarzana

Our programs are looking for additional volunteers to help those in need. The Foundation pays all required lab fees and volunteers provide the expertise in their own offices. Call Wendy at the central office, 818.576.0116, to sign up and help a patient who has no means to pay for desperately needed dental treatment.

The Complexities Of Designing A New Dental Office

By: George Fedyana

I am a Certified Interior Designer specializing in dental office design for more than 30 years. During this time I have seen numerous changes in dental office requirements from many standpoints like esthetics, overall square footage needs, operatory sizes, Americans with Disability code requirements, and various city, state and federal code requirements, etc. I would like to address some of these important issues so you know what to expect when looking for a new space and save yourself expense and time delaying disappointments.
When you decide to move or add a location there are a number of questions you should ask yourself:

-How much space do I need?

If you haven't moved or opened a new office in more than three years, you may be surprised to learn that the building codes have changed during that time and will require more space than previously needed.

This means if you are moving your existing office into a new space and expect to fit it into the same square footage you may be disappointed because your new space will require more square footage to meet the new codes and pass through the city's plan check requirements.

-What is the difference between Rentable and Usable square footage?
Your landlord or real estate agent will provide you with a square footage number. It is important to know exactly what is or isn't included in that number.

'Rentable Square Footage' may include percentages of common hallways and the space within common or exterior walls, which will result in you having less build-out square footage. What you need to know is the 'Usable Square Footage'. That is the square footage within your suite to use for build-out, plus some distances of outside walls. It is best to have the space measured taking into consideration any physical obstacles like posts and angled or curved walls so you know exactly what you have to work with.

-Do I Have Enough Parking?

In California this is a very big issue. One of the first questions you should ask your landlord is how many parking spaces are available to you for a dental office. If you don't have enough parking spaces you may not be allowed to open your office in that location without going through variances which are very costly.

-What are Path of Travel discrepancies?

In California there must be an unobstructed path from the street, lobby, halls and elevator to your suite, and the path must meet all "Americans With Disabilities Act" codes. California requires that 20% of the assessed value of your project be allocated to disabled access path of travel.

It is crucial that you check your lease to be sure your landlord is not charging you for this disabled access percentage.

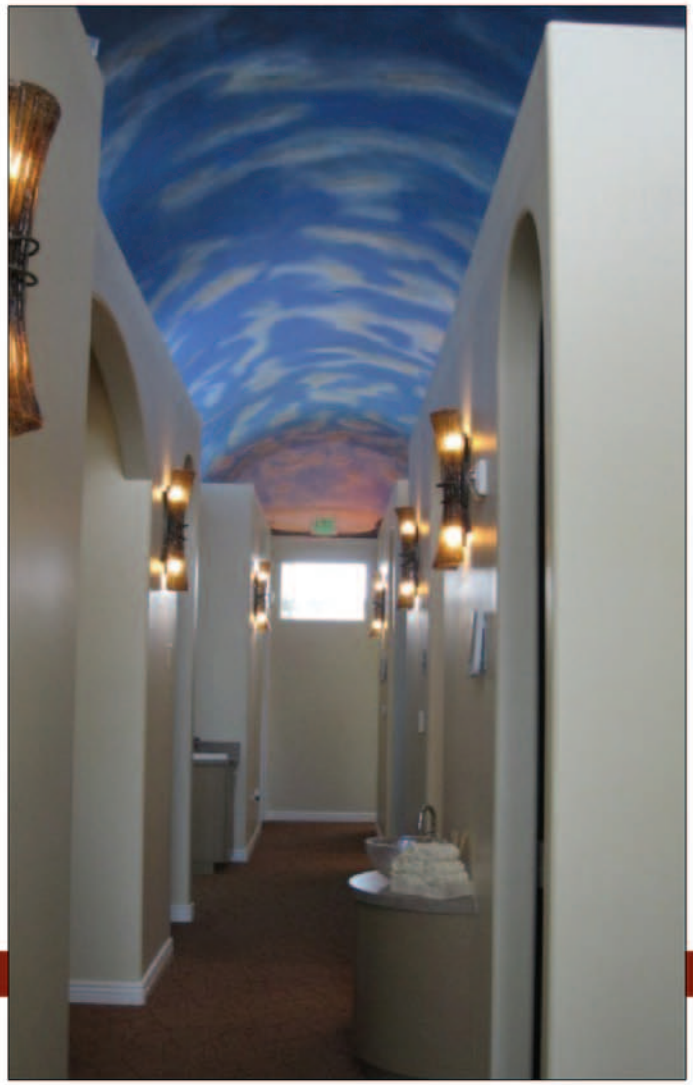
That means that they would be charging you to make their property compliant and you would receive no direct value from that expense.

-Leasehold Improvements

As part of the lease negotiation you should ask for leasehold improvement monies which usually includes a certain number of rent free months and a percentage toward the build-out costs. These benefits vary from landlord to landlord and there are a number of things to be considered:

- Are you getting rent lower than other rents in the area?
- Are you getting free rent (your free rent should begin once the building permit is issued)?
- Build-outs cost more in high rise buildings.
- How long is your lease? Are there any options for renewal, etc.?

I recommend you have an attorney or a dental lease negotiator review your lease to be sure all of your bases are covered.



When considering a new office I would recommend you make a list of the many things that must be considered and put the items in chronological order.

- Determine general location.

- Find a commercial real estate agent specializing in medical/dental offices and/or provides lease negotiations.

- Contact an Interior Designer specializing in dental office design and has a complete understanding of building codes.

There are so many things to consider when designing a dental office and only a few have been addressed. If you have any questions or would like more information feel free to contact me through my website: http://www.uniqueinteriordesigns.com

Peace of Mind, Body and Soul

By: Karin Irani, DDS, SFVDS Treasurer

The San Fernando Valley Dental Society held its 4th Annual, Afternoon Tea Party on September 12, 2015 at the Breamar Country Club. This event was sponsored by two of SFVDS's great supporters, Linda Brown of Told Partners Realty, and Bonnie Bradbury of Fortune Management.

Once again female dentists from Los Angeles joined their colleagues from SFVDS and CA, and had the opportunity to meet some of the CDA and ADA female leaders. Dr. Lindsey Robinson ADA District 13 Trustee, gave an update on the latest developments at the ADA level, including the new partnership between ADA and DRB to provide members with exclusive student loan refinancing.

Dr. Kerry Carney, CDA Editor-in-Chief, shared with the group that she was the only female dentist on the board of CDA when she joined the board. She was extremely happy to be able to attend the Afternoon Tea Party this year to meet many of the female dentists in the Los Angeles area. She encouraged all to get more involved in organized dentistry and follow their passions.

This year the group was joined by life coach, Dr. Maryam Hadian, who is also a dentist herself, raising two small girls and running a full time practice. Dr. Hadian helped the group with tools and recommendations on how to build a successful, stress-free life. She used some of the challenges and scenarios mentioned in past gatherings and presented the group with suggestions on how to face daily practice and life concerns. She explained that in order to have a successful life, we have to let go of some of the things or people that cause conflict.

She also answered questions that attendees brought up on how to solve some of their office conflicts peacefully. This year, attendees received a rainbow of clutches as party gifts. After enjoying tea sandwiches and pastries, guests left refreshed and more confident in being able to address many of the specific life challenges female dentists face.

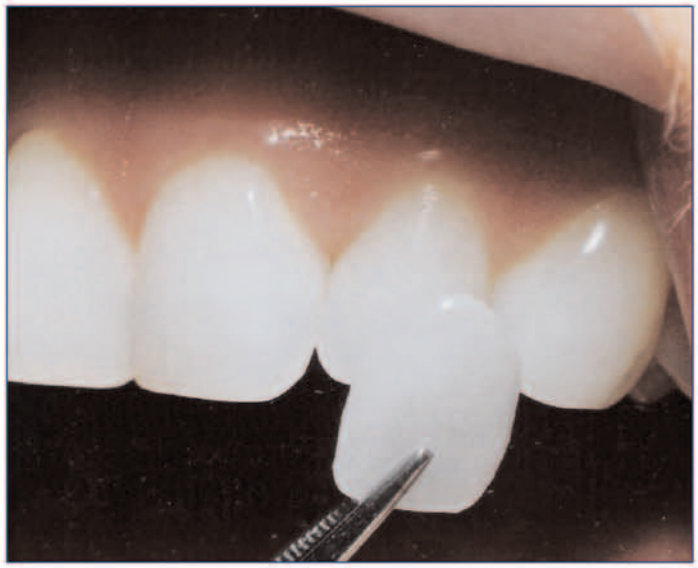
I hope to see many more of women dentists join us next year as word travels about the helpfulness of the event.

Precise Documentation is an Advantage in Veneer Cases

Risk management articles and seminars often look at problematic cases where things go wrong during dental treatment, but let's turn the tables and see what happens when a case goes right.

The following case involves the placement of dental veneers, a procedure that generates numerous questions, according to risk management analysts at The Dentists Insurance Company. TDIC reports regular calls to its Advice Line about veneer-related situations, and numbers show that veneer cases are sent to claims more frequently than cases involving other dental issues. In a recent two-month timeframe, Advice Line calls revealed 10 of 12 veneer-related calls ended up in the claims department. "Veneer cases can be difficult," said a senior risk management analyst with TDIC. "There is not one easy answer."

Risk management analysts are clear, however, that dialing the Advice Line does not mean your call is automatically sent to claims. Based on the facts of the call, the analyst



may determine the case is beyond risk management and refer the caller to the claims department.

Some veneer cases have a more positive outlook than others. Here's an example: Last October, a Northern California dentist placed five anterior veneers on a 29-year old patient. The dentist discussed the procedure with the patient, and she signed an informed consent form. The dentist also charted the discussion and procedure and took photos, including a final photo of the smiling patient with the new veneers in place. The patient even gave a "thumbs up" in the photo.

The dentist was surprised when the patient called a month later and demanded a refund. She said another dentist had to "fix" the veneers. The dentist called TDIC's Advice Line to discuss options about the best way to proceed.

The risk management analyst asked the dentist about documentation surrounding the case. He had appropriate chart documentation, photos and the informed consent form. He said he took time to explain the procedure, including tooth preparation, and noted the conversation in the dental record. This documentation gave the dentist an advantage because he felt the veneers were clinically sound, and he had the evidence to back it up.

The TDIC analyst recommended the dentist tell the patient he was willing to investigate further. The dentist should then ask the patient for permission to speak with the new dentist who fixed the veneers, so he could learn what was allegedly wrong.

In this case, the burden is on the patient to prove there is a complication with the veneers, and the dentist is poised for a favorable outcome thanks to good clinical work and record-keeping.

Unfortunately, not all cases go this way.

Continued on page 21

By: TDIC Risk Management Staff

"Some would say we preach documentation," said a TDIC risk management analyst. "Yet, in too many cases we find the documentation is spotty or incomplete. What we see is a lack of signed informed consent forms for invasive procedures such as veneers and no documented patient esthetic approval prior to the permanent cementation of veneers."

Dentists have told analysts that patients often assume if they do not like the veneers, then the veneers can just be removed with no consideration of tooth coverage. The issue is whether the doctor was clear during the informed consent discussion that the tooth preparation is irreversible and veneers cannot simply be taken off.

Informed consent discussions about veneers include essential information about tooth preparation, potential consequences and possible alternatives. If orthodontics or periodontal surgery is recommended but the patient chooses veneers instead, be clear verbally and in writing about the risks, benefits and alternatives to veneers.

Equally as important are questions about what the patient expects from the treatment. Patients may bring pictures of celebrities they admire. Often the patient is looking at the overall appearance in the photo rather than just the teeth. Other times the patient is seeking a more youthful appearance. As a prominent dental attorney advises, "There needs to be a meeting of the minds about the patient's expectations and the limitations of dentistry. Communicate what you can accomplish compared to what the patient expects, and make sure the patient hears you."

Document the conversation and include the patient's comments and questions. Keep consistent records throughout the treatment including progress notes, findings, patient and clinician concerns, and photographs. Claims professionals emphasize the importance of the dental record for continuity of care and keeping the facts straight. Without consistent and thorough recordkeeping, it is difficult to remember everything for every patient, especially relating to treatment that may have happened several months or even years ago.

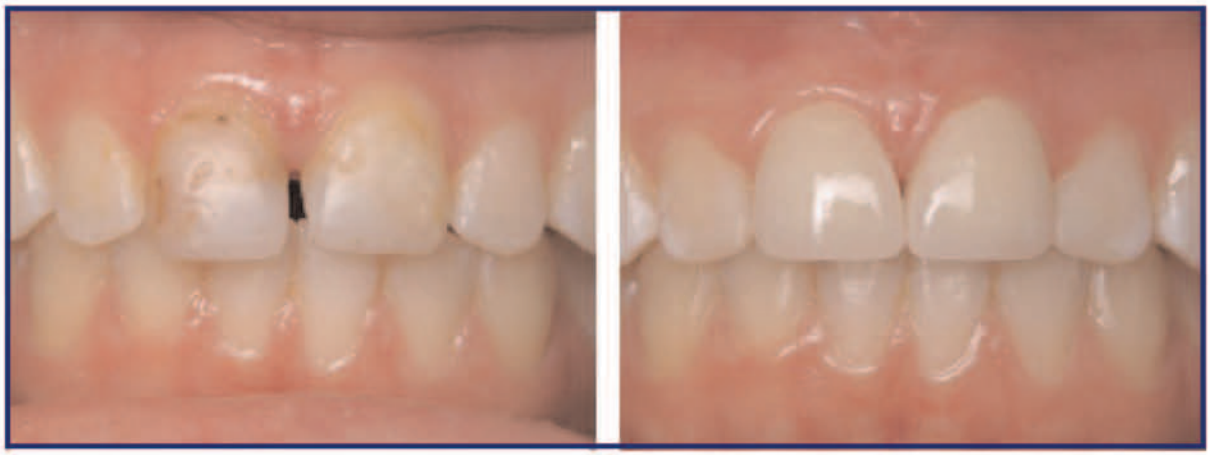
Additionally, risk management experts always advise dentists to pay attention to any intuition they may have about a patient. This is especially true during an informed consent discussion about veneers. The desire for cosmetic procedures may be tied in with complex emotions, and the patient may be seeking a cure-all or miracle that even superior dental work cannot deliver. You are not obligated to take on every case that comes your way. As one well-known esthetic dentist put it, "In one instance, my best cosmetic case was one that I never started."

Key Recommendations

To boost the success of veneer cases, TDIC strongly recommends the following:

- Communicate clearly with the patient about the irreversible aspect of porcelain veneers. Discuss tooth preparation, potential consequences and alternatives.
- Ask the patient to sign an informed consent form. Informed consent forms are available at thedentists.com.
- Chart the informed consent discussion, treatment plan and progress notes in sufficient detail.
- Photograph the procedure from start to finish.
- Prior to cementation of veneers, ask the patient to sign an esthetic approval form. Esthetic approval forms are available at thedentists.com.

TDIC's Risk Management Advice Line can be reached at 800.733.0634.



BEFORE AFTER

This shows old bonding and diastema (space) restored with procelain veneers.

Antelope Valley Report

By: Kathy McKay

Hi Desert Children's Dental Clinic Receives $6,500 Donation!

Each year Kids Charities hosts the Thunder on the Lot event. Kids Charities now serves more than 30 local children's charitable organizations. The organization's goal is to help the children in the community who need it most. Since its inception, Kids Charities has raised more than $4 million dollars to assist Antelope Valley children. Kids Charities has five primary functions:

1. Fundraising to raise money and in-kind donations efficiently

2. Community Service to promote and coordinate volunteer support of service providers.

3. Fund Distribution to distribute charitable funds to the most effective service providers.

4. Community Building to build alliances among charities, businesses and other entities in support of the community.

5. Publicity to execute support through events, promotions and awareness campaigns.

Glendale Foothills Report

By: Chi Leung, DDS

We recently hosted the first CPR class in the Glendale/Foothills area and a total of eight dentists and staff were in attendance. This course covered the latest techniques and training for the re-certification of CPR. More CPR re-certification classes will be offered in the fall, and are offered at the discounted rate of $35, $5 of which is donated to the SFVDS Foundation.

I have volunteered to provide dental care for three uninsured family members for the Foundation's Smiles From the Heart Program. As a dental professional, giving back to the community and providing help to patients in dire circumstances is one of the most enriching and rewarding experiences I have had. I would encourage other dentists to come forward to volunteer as well, as we need the help.

Sergio Castellano conducts a CPR recertification class in Glendale

Save the Date!

SFVDS Annual Holiday Social

December 4, 2015

6PM – ??????

DJ, Dancing, Good Food, Networking, Wine & Beer

Watch your emails in November for more details.

Welcome New Members

Igor Roshkovan, DDS
14100 Victory Blvd.
Van Nuys, CA 91401
General
818.908.9799
Univ del Bajio A C, Mexico, 2012

Philomena O. Oboh, DDS
14434 Hamlin St.
Van Nuys, CA 91401
General

Mona Hadaya, DDS
General
USC, 2008

Deema Saad, DDS
4910 Van Nuys Blvd Ste. 100
Sherman Oaks, CA 91403
Endodontics
818.319.4342
UCLA, 2010

Rebekah Ehde, DDS
General
USC, 2010

Lucia Paxton, DDS
20301 Ventura Blvd. #218
Woodland Hills, CA 91364
General
818.378.0708
UCLA, 1981

Saman Saghizadeh, DDS
General
NYU, 2013

Peyman Saghizadeh, DDS
General
NYU, 2013

Razmik Galustian, DDS
10400 W. Magnolia Blvd.
North Hollywood, CA 91601
General
UCLA, 2010

Gloria Garcia-Gonzalez, DMD
12926 Sherman Way
North Hollywood, CA 91605
General
University of Puerto Rico, 2011

Andre Eliasian, DDS
General
NYU, 2013

Robert Anderson, DMD
1138 North Brand Blvd.
Glendale, CA 91202
Endodontics
818.552.3636
Oregon Health Science University, 2006

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